Labor Standards Division
Arkansas Department of Labor
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Application for Authorization to Employ Workers with Disabilities at Special Minimum Wages

This is an application for the authorization to employ workers with disabilities at special minimum wage rates under ACA 11-2-214. An instruction sheet for completing this form is contained on page 5. Please submit one copy of the completed form, and any attachments, to the address shown above. Retain a completed copy for your records. A certificate may not be granted unless a properly completed application has been received and approved.

1. A. This is a request for authorization to employ workers with disabilities for (check all boxes that apply):
   - ☐ Community Rehabilitation Center (Work Center)
   - ☐ Hospital/Residential Care Facility (Patient Workers)
   - ☐ Business Establishment (Special Workers)
   - ☐ School Work Experience Program (SWEP)

   B. This is (check one):
   - ☐ Initial Application (Complete all items)
   - ☐ Renewal Application (Please make any necessary corrections to reprinted information)

   Current Certificate Number: _____

2. Name of Employer: _____
   Street Address: _____
   Mailing Address (if different than street address): _____
   City: _____ County: _____
   State: _____ Zip Code: _____
   Federal Employer Identification Number (EIN): _____
   Person ADL Should Contact: _____
   Telephone: AC(____) _____

3. Parent Organization (if different from that listed in #2):
   Name: _____
   Address: _____

   ☐ Check here if mail is to be sent to parent organization rather than #2.

4. Status(check one):
   - ☐ Public (state or local government)
   - ☐ Private, For Profit ☐ Private, Not For Profit
   - ☐ Other _____

For ADL Use Only

Certificate Number: _____
Effective Date: ____/_____/_____
Expiration Date: _____/_____/_____
RO: _____ DO: _____
Remarks: _____
Employees: _____
Paying SMW's: Yes ☐ No ☐
Number of Sites to Receive a Certificate: _____
Print Certificate Yes ☐ No ☐ WS: _____

5. Primary disability group employed (check one):
   - ☐ Mental Retardation (MR) ☐ Mental Illness (MI)
   - ☐ Drug Addictions (DA) ☐ Alcoholism (AL)
   - ☐ Age Related (AR) ☐ Neuromuscular (NM)
   - ☐ Hearing Impairment (HI) ☐ Visual Impairment (VI)
   - ☐ General – No Primary Group (GI)
   - ☐ Other (OT) Specify: _____
   - ☐ Developmental Disability (DD) Specify: _____

6. List the name and address(es) of all branch establishments (BR), supported employment sites, including enclaves (SE), or school work experience program sites (SWEP) to be covered by this certificate. Note: list each establishment where you employ workers with disabilities at special minimum wages (including your main establishment and each establishment listed below). See page 4 of this application for definitions of BR, SE and SWEP. Attach additional sheets if necessary.

Indicate if BR, SE or SWEP	NAME & ADDRESS OF SITE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

7. FOR RENEWAL APPLICATIONS ONLY. Please provide the number of workers with disabilities (whose productive capacities were impaired by their disabilities and were paid special minimum wages) that your firm employed during your most recently completed fiscal year. Please provide this data using the categories listed below:

Number of workers employed in or as (complete each item as applicable):

☐ Work Center: _____ ☐ Patient Worker _____ ☐ Business Establishment _____ ☐ SWEP _____

Also, provide the date your most recently completed fiscal year ended: _____/_____/_____

8. PREVAILING WAGE DETERMINATION. Please provide the following information on the four largest current contracts whether the workers with disabilities are paid an hourly rate or a piece rate. The prevailing rate should reflect the rate paid to experienced workers in the vicinity who do not have disabilities and utilize similar methods and equipment. If more than 3 sources were used, attach an additional sheet headed "Prevailing Wage Determination" and provide the information obtained from these sources.

Description of Work (collating, hand assembly, janitorial)	Sources (Name of Firm and Person Contacted)	Date of Contact	Prevailing Wage Provided By Source	Prevailing Wage Determined by Applicant
	1. _____ 2. _____ 3. _____	_____ _____ _____	$ _____ $ _____ $ _____	$ _____
	1. _____ 2. _____ 3. _____	_____ _____ _____	$ _____ $ _____ $ _____	$ _____
	1. _____ 2. _____ 3. _____	_____ _____ _____	$ _____ $ _____ $ _____	$ _____
	1. _____ 2. _____ 3. _____	_____ _____ _____	$ _____ $ _____ $ _____	$ _____

9. HOURLY RATES

a. If this is a renewal application, how many workers with disabilities employed under the terms of this certificate received special minimum wages and were paid hourly rates during the fiscal year cited in Block 7 above? (If the answer is 0, go on to question 11): _____

b. How frequently do you rate/evaluate the productivity of each hourly paid worker with a disability who is paid a special minimum wage? _____

c. Attach to this application productivity rating/evaluation forms for three currently employed workers with disabilities who are paid hourly rates (if you employ workers with disabilities at special minimum wages on an SCA contract, one of the three employees for whom data is submitted must pertain to an SCA service employee). Include all material relating to the evaluation which shows the worker's individual productivity in proportion to the wage and productivity of an experienced worker, who does not have disabilities, performing essentially the same type, quality and quantity of work in the vicinity.

10. PIECE RATES

a. If this is a renewal application, how many workers with disabilities employed under the terms of this certificate received special minimum wages and were paid piece rates during the fiscal year cited in Block 7 above? (If the answer is 0, go on to question 11). _____

b. Please provide the following information about the four largest current contracts on which workers with disabilities earning special minimum wages are paid piece rates and attach supporting time studies or work measurements.

Description of Work (packaging, shrink wrapping, labeling)	Prevailing Wage Determined for this job (Expressed in a rate per hour)	Standard Productivity (Units/Hour)	Piece Rate Paid to Workers (Rate per Unit)

11. TEMPORARY AUTHORIZATION: To be completed **only** by a vocational rehabilitation program administered by a State agency or the U.S. Veterans Administration.

Check here ☐ if this is a request for temporary authorization to employ workers with disabilities at special minimum wages pursuant to a vocational rehabilitation program of the Veterans Administration for veterans with a service-incurred disability or a vocational rehabilitation program administered by a State agency. A copy of the signed application will constitute the temporary authorization provided the application is mailed to the Department of Labor at the address listed at the top of page 1 of this form within ten days of the signing. Temporary authorization will exist for 90 days from the date the application is signed and cannot be extended or renewed by the issuing agency.

12. REPRESENTATIONS AND WRITTEN ASSURANCES

I certify that I have read this form and to the best of my knowledge and belief, all answers and information given in the application and attachments are true; that the representations set forth in support of this application to obtain or continue the authorization to pay workers with disabilities at subminimum wage rates are true; and that the authorization, if issued or continued, is subject to revocation in accordance with the provisions of state law.

I represent that as set forth in the regulations governing the employment of workers with disabilities, the following conditions exist (or will exist for initial applicants):

(1) workers employed (or who will be employed) under the authority of ACA 11-2-214 have disabilities for the work to be performed;

(2) wage rates paid (or which will be paid) to workers with disabilities under the authority in of ACA 11-2-214 are commensurate with those paid experienced workers, who do not have disabilities, in industry in the vicinity for essentially the same type, quality, and quantity of work;

(3) the operations are (or will be) in compliance with federal and state wage and hour and child labor laws;

(4) no deductions will be made from the commensurate wages earned by a patient worker to cover the cost of room, board or other services provided by the facility; and

(5) records required by agency regulation with respect to documentation of disability, productivity, time studies or work measurements, and prevailing wage surveys will be maintained.

Further, I certify that:

(1) the wage rates of all hourly-rated employees will be reviewed at least every six months; and

(2) wages paid to all employees will be adjusted at periodic intervals, at least once a year, to reflect changes in the prevailing wage paid to experienced workers, who do not have disabilities, employed in the vicinity for essentially the same type of work.

13. SIGNATURE OF AUTHORIZED REPRESENTATIVE:

Name (Print or Type) _____ Title :_____

Signature _____ Date: _____

Data Sheet for Application for Authorization to Employ Workers with Disabilities at Special Minimum Wages

Complete this form for every establishment/worksite where you employed workers with disabilities at special minimum wages during your most recently completed fiscal quarter and submit with the Application for Authorization to Employ Workers with Disabilities at Special Minimum Wages. These establishments/worksites must also be listed on Item 6 of the application. Complete this form if you are a business establishment proposing to employ specific worker(s).

1. **Name of Worksite** _____

2. **Address of Worksite** _____

_____

_____

_____

3. **This worksite is** ***(check one)***

____ **ME** Your main establishment
____ **BE** Branch Establishment
____ **SE** Supported Employment Site, Including Enclaves
____ **SWEP** School Work Experience Program Site

4. **Enter the ending date of the most recently completed fiscal quarter for which you are providing information in Items 5 through 9 below:** _____ / _____ / _____

5. **Is Service Contract Act work performed at this establishment/worksite?** **YES** ____ **NO** ____

Below, list all employees with disabilities paid special minimum wages during your most recently completed fiscal quarter. You may submit the following information in alternative formats, for example computer printouts, as long as all the requested information is included. You may attach additional sheets as necessary.

6. Name of Worker with a Disability	7. Primary Disability	8. Type of Work	9. Average Earnings per Hour

10. **Enter the total number of unduplicated employees who are employed at this work site and receive special minimum wages.** _____

INSTRUCTION SHEET

GENERAL INSTRUCTIONS

1. This application is to be used to apply for a subminimum wage certificate pursuant to ACA 11-4-214. Payment of subminimum wages to workers with disabilities is authorized by state and federal law. The Arkansas Department of Labor will accept and recognize such certification issued by the U.S. Department of Labor, Wage and Hour Division, provided at least 85% of the state minimum wage rate is actually paid. **If federal minimum wage is higher than 85% of the state minimum wage rate, you must obtain certification from the U.S. Department of Labor, Wage and Hour Division.**

2. This application process is authorized by ACA 11-4-214. While completion of this form is voluntary, authorization to pay less than the applicable minimum wage will not be granted unless a properly completed application is submitted.

3. Complete one copy of this form and send it to the address shown at the top of page 1. Keep a copy of the application for your records.

4. For item #1: A **community rehabilitation center** (often in the past referred to as a sheltered workshop) is a facility that is engaged primarily in providing rehabilitation and employment opportunities to workers with disabilities. A **patient worker** is a worker with a disability who is employed by a hospital or institution that provides residential care where such worker receives treatment and care. A **business establishment**, for purposes of this application, is an employer in private industry (who is not a work center or employer of patient workers) that is seeking permission to employ workers with disabilities at special minimum wages. A **school work experience program** (SWEP) is a school operated program by which students with disabilities may be placed in jobs with private industry within the community.

5. If you operate a work center and employ patient workers, you will receive two separate certificates. Likewise, you will receive separate certificates for each branch establishment and school work experience program site. Workers with disabilities paid special minimum wages who work at supported employment sites, including enclaves, however, are covered by the certificate issued the main establishment of the supervising work center .

6. For item #6: A **branch establishment** is a physically separate establishment of the same enterprise. A **supported employment work site** is a location, outside of the work center or rehabilitation center, often on the premises of an enterprise separate from the work center or rehabilitation center, where workers with disabilities paid special minimum wages are placed in employment settings along with work center staff (job coaches). An **enclave** is a supported employment work site where a group of workers with disabilities is working and supervised by staff from the work center. A **school work experience program** (SWEP) site is a workplace in the community in which a school system has placed a student(s) with disabilities to work in a job(s) at special minimum wages.

SPECIAL INSTRUCTIONS FOR SCHOOL WORK EXPERIENCE PROGRAMS (SWEPS):

The rehabilitation counselor or coordinating official of the school may submit a group application covering all of the students with disabilities and all of the employers participating in a school work experience program. Employers are responsible for compliance with all applicable child labor laws, minimum wage standards, certificate and recordkeeping requirements. The students participating in a school work experience program must be paid commensurate wage rates based upon the students' productivity in proportion to the wage and productivity of experienced workers who do not have disabilities performing essentially the same type, quality, and quantity of work in the vicinity in which the students are employed. Complete all items except 12.

Item 1(A)	Check "School Work Experience Program"
Item 2	Enter identifying information for school
Item 3	Enter School District information
Item 4	Check "Other" and enter "SWEP"
Items 8 and 10	Complete for the four types of work in which the greatest number of students with disabilities are employed at special minimum wages. If fewer than four types of jobs exist, enter "n/a" in the "Description of Work" blocks which are not used.
Item 13	Must be signed by the counselor or coordinating official of the school

SPECIAL INSTRUCTIONS FOR VOCATIONAL REHABILITATION COUNSELORS OR VETERANS ADMINISTRATION TRAINING OFFICERS REQUESTING IMMEDIATE TEMPORARY CERTIFICATION TO PAY SPECIAL MINIMUM WAGES: Complete all items of this application.

Item 1(A)	Check "Business Establishments (Special Worker)"
Item 2	Enter name and location of employer where workers with disabilities are to be placed
Item 3	Enter the name and address of the Veterans Administration Office or State Vocational Rehabilitation agency which is seeking temporary authorization
Item 4	Check "Other" and enter the type of business in which the worker with a disability is being placed
Items 8 and 10	Complete for the work sites where the workers with disabilities will be employed at special minimum wages
Item 11	Check the box
Item 13	Must be signed by the Vocational Rehabilitation Counselor or Veterans Administration Training Officer